System Transformation Initiative

SeaTac Holiday Inn
Seattle, Washington

MEETING NOTES

April 18, 2007

PRESENT: Doug Mayer, Makah Nation; Linda Thomas, Skokomish Tribe; Jeanne Paul, Shoalwater Bay Tribe; Adrianne Hunter, Upper Skagit Tribe; Shawn Yawity, Stillaguamish Tribe; Edward Reser, Stillaguamish Tribe; Jennifer LaPointe, Puyallup Tribe; Sheryl Fryberg, Tulalip Tribe; Andy Keller, Peter Selby, Jenifer Urff, and Maria Monroe-Devita, Consultants; Sharri Dempsey and Doug North, Indian Policy; Andy Toulon and Gaye Jensen, Mental Health Division

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Very Important Issue of Concern to the Stillaguamish Tribe:

- Previously the Tribe could bill directly to Medical Assistance for certain services, but now they have to go through the RSN to bill for those same services. However, the RSN said they could not contract with the Stillaguamish Tribe because they were not licensed though the State. They never gave up their right to bill directly. The Tribal representatives were not told about this until the last minute. They also want to know if they will be able to eventually recoup expenses to date.

- The Stillaguamish want to be able to treat people in their whole situation. They have become a community service and don't turn anyone in need away. As their rep pointed out, "To be successful, we need the State and County to be with us!" Success in one area leads to success in the other areas of need. They need a full array of services to help people make a difference in their lives. The Tribe wants to be treated individually, they do not wanted to be treated the same as everyone in a large group. Other billing details about their particular situation:

    - The Tribes serves native and non-native people

- They used to bill directly for Medicaid services through MAA for services to non-native people
- Everything changed June 15, 2006 and was not an issue before that
- They asked for information from the RSN ahead of time before the RSN Board presentation but did not receive anything.

- Comments from other participants at the focus group were that it may be a federal issue and that there are issues about defining who is a part of the "clinical family". To someone else it seems like it should be a direct MHD-Tribal issue.

- The Stillaguamish Tribe will be sending a letter voicing these frustrations.

- The Puyallups are also struggling with the same issue of state licensing/certification relevance. Counselors are not Native American specialists. In their situation, the RSN was trying to help.

  The state licensure/certification issue is happening in other places, for example with the Area Agencies on Aging. (AAAs and DASA)

  This is a common theme for other Tribes. The Puyallups can meet licensing requirements, but they know the implications for the other Tribes if they go through this process of licensing. They don't want to set an impossible standard for the small Tribes.

- This issue is very frustrating to the Stillaguamish. They have been in many meetings where this has been brought up; but no one says they have the authority to do anything. They ask: who can help solve this problem? In their opinion, this shows the lack of understanding of the government-to-government process. Their Tribe is lumped into a group, but their needs are different. It washes away the purpose of government-to-government, and is disrespectful. They do not feel that their issue is addressed—they want the government-to-government process with them alone. Their issue is not getting the right attention, their staff have been discredited, and they have had to send letters to defend their situation.

- Andy Toulon noted that the message will be taken back to headquarters and that the Tribe can request a formal consultation by asking either the Governor's Office, the Secretary of DSHS, or the Mental Health Director.

- In summary, there seems to be two issues in this discussion:
  - The specific problem facing the Stillaguamish Tribe over billing and solving it through the government-to government process
  - The global issue of DSHS contracting out services through another entity which then requires certain licensing for the sub-contractor which may be difficult for a small Tribe to meet

Medicaid Benefit Package Presentation/Discussion:

- Basically, Tribal mental health is a fee for service model. It is hard to start a mental health program from scratch with this funding model. Could there be a model for "base funding" to get started?

- It's hard to know who (Tribes and RAIOs) has a mental health program as it can look differently in each place.

- Might be good to get a clear picture of mental health services/system in each tribe and community forth formal and informal, including a description of base funding

- Takes effort to translate jargon to common language to relate to what Tribes do

- Tribes are unique—you can't generalize from one to another. From the Indian perspective, people have "gifts" to help one another that are valued within the culture, but not something that you bill for, for example, spiritual healing.

- Evidence-based practices (EBPs) are a concern and how they fit. Typically, there are no EBPs for Indian people on the matrices that are put together. The process typically screens Tribes and RAIOs out of the competitive process.

- There is concern that contracts are leading to only contracting for EBPs down the road

- Have to recognize the money it takes to implement EBPs.

- People would like to be able to bill for traditional medicine. (Would probably require an intense consultation process to determine.

- There may be some applicable examples in Arizona, Alaska, and New Mexico.

  EBPs for children—it is more of a norm for children in Indian Country to live with relative. The majority community doesn't see or understand that this isn't necessarily a bad thing.

- The "rules" have unintended consequences, like background checks for relatives (who often share in raising Indian children) that can make placement of Indian children more difficult

- Other challenges—when there are program Tribal liaisons (from the bureaucracy), they don't always come to meeting, like the Regional Tribal Coordinating Committee (RTCC). It might help if they were put under the Director for visibility purposes.

- A part-time position for all Tribes, all RSNs, etc, is unrealistic, especially when there aren't structures for regional staff/offices (like MHD which does not provide direct community services). Perhaps east and west reps would help.

- One of the problems is the lack of information. There are big gaps in understanding how each other's operations work. Liaisons just need to show up and not worry about agenda-specifics.

Focus Group Recommendation: Send out draft or pre-summary of STI Report Tribal Chapter to Tribal Chairs before the May 18th Mental Health-Tribal Meeting. Refer to the Communication Protocol in the 7.01 Policy for more information.

- Be aware of all definitions of "recovery and resiliency" from tribal perspectives. The group suggested that the Health and Recovery Services Administration (HRSA) come up with a definition as well. Andy Toulon pointed out that the Legislature has a definition, too.

- There is no system in place to address COD (i.e., mental health and substance abuse). How do Tribes get whatever model is chosen to be recognized? In Tribes, one person can easily be doing both functions. Billing for an encounter becomes an issue—which program area do you bill?

- Another problem is that if someone is under a court order, the Court may only recognize certain treatment providers, like chemical dependency, but it is the mental health staff in that particular instance that is already doing it within their treatment approach.

- The current plan is lacking coding guidance (for billing).

- Access to Care Standards—lots of heartburn over this in Indian Country. It's the interpretation, not just the standards per se that is the problem. The Tribes need to figure out their own interpretation.

- In some states, for example, Arizona, they have a choice in how they bill. Washington provides separate encounter for mental health and substance abuse. States can have multiple options.

- Caution—be careful when talking about or highlights the issues of encounter billing—don't want that option to be taken away!

PACT Presentation/Discussion:

- How much do beds cost in jails and prisons compared to the state hospitals?

- There is an issue of drug-affected infants who will always need extra support in their lives

- Tribes have been doing "it" (PACT) for thousands of years!

- If an Indian person is served on a PACT team, what is the connection to their Tribe? How does a Tribe connect a member to a PACT team? Also, how is housing handled? Many people in need are homeless. (Reply: PACT funds are mostly for

services. Expectation is that communities will work on housing and leverage PACT funds to raise other monies.)

- Landlords tend to have criteria, like no history of fire setting or inappropriate sexual behavior. Will PACT work with them? (Reply: yes, PACT will work with landlords.)

- What is the priority for placement? (Reply: State hospital clients are a priority, but there are slots for other, too. The legislature required that there be a reduction in state hospital utilization. Wards are to be closed later, not right when people move.)

- Will there still be beds to serve people in crisis? (Reply: Yes, there will still be more beds available after the reduction and there will be $10 million more in the community that wasn't there before.)

- How does someone get accepted by a PACT Team? (Reply: 9 RSNs have been selected to date. There are statewide criteria for being chosen to participate.)

- Can people with developmental disabilities be in PACT? (Reply: Typically not.)

- It seems like there would be major communication/collaboration issues for Indian people on a generic PACT Team. There seems to be a disconnect between where service/resources are and where the person is. (Reply: The intensity of PACT staffing will hopefully lead to better linkage and communication.)

- PACT seems to exclude Indian County because most people don't want to go outside their community for services. Perhaps the PACT model is more adapted to an urban environment for people who don't live on the reservation.

- Can a person on a PACT Team continue to see a non-PACT therapist? (Reply: It is hard to justify financially, but there should probably be an exception process for cultural reasons. PACT is not an alternative to services that work, but an alternative to bad situations, like being in jail.

- It's about truly culturally competent services. Eventually, we should have Tribal PACT Teams.

- If Indian people are served by PACT, there should be communication working agreements or understandings, written now, before something negative happens.

- For rural tribes, it is very hard to see people have to leave their community to get a service.

- Really like the model, though!

- Historically, the Mental Health Division has spread resources too thin. It would be of concern if the model had too many exceptions going on. It might be better to look to expansion rather than "thinning the soup".

ITA Presentation/Discussion:

- This is a statutory review around adults. However, there are age of consent issues for youth.

- We need more inpatient beds for children. You have to go out of state to place kids.

- Children are in Tribal custody/Family Court. The Tribe pays for the treatment.

- (6When systems collide (over age of consent), it just creates barriers to service. There are conflicts between jurisdictions. Many times it is not known that there is Tribal jurisdiction. Our contractors are not held to federal statutes which lead to more conflict.

- Tribal Courts supersede county and state courts.

- Where is the "full faith and credit" of the credentials of another professional? (during intake)

- It seems that in areas where there are collaborative Child Protective service or Adult Protective Service agreements, there is full faith and credit in other areas, as well.

- Kitsap County has some agreement where they expedite a referral without re-evaluating the person and redoing the work.

- In Regions 3 and 5, there was an agreement for Indian people to be voluntarily hospitalized. It is not the same everywhere.

- Tribal Courts decide the service plan and the State pays.

- In JRA, the Colville Tribal Court has a pilot agreement that allows them to commit directly to JRA when necessary.

- You need to have or know the protocol for making the connection to get a DMHP onto the reservation.

- There is nothing at this time in Designated Mental Health Protocols that addresses this issue.

- There needs to be a Tribal code (for billing).

- It also depend on the RSN and their contracted provider about how they do crisis services.

- When people are discharged, Tribes are typically not involved or contacted.

- The best practice is to notify Tribes when they come in for services at the beginning- that leads to contact when they are leaving, especially if they don't go back to the reservation.

- Some RSNs are waiting for "permission" from MHD (DSHS management) to negotiate with Tribes as they only do what's in their contracts.

- Can we use the 7/01 Plan process to negotiate relationships? This is working in some places? (Reply: RSNs are required to develop a Tribal collaboration plan with each Tribe in their designated area. Some do a better job than others.) However, none are monitored at all.

- Some Tribes will prefer to deal with the State over the RSN or with the Feds over the State.